March 1992, **160**, 425), which are quite similar to our experience here in Hong Kong with the Chinese population. The very discussion of the applicability of Western psychotherapy to a non-Western population raises the issue of whether non-Western cultures have the same psychological problems as are found in the West, which are dealt with by their psychotherapy. Doi (1984) has questioned this assumption, although with increasing Westernisation of the non-Western cultures, we may also acquire their problems.

There is no Western 'model' of psychotherapy but Western 'models' of psychotherapy (Karasu, 1977). It has been found, within Western society, that sub-cultural groups respond to different therapeutic approaches differently. Our difficulties with the non-Western population may be a reflection of similar difficulties with specific sub-cultural groups in the West.

No two patients are the same, and indeed, no two therapists are the same, each therapy session with each patient by a specific therapist is in some sense specific, and influenced by a whole gamut of factors impossible to disentangle. Ethnicity of the patient is only a particular aspect of this specificity.

It may be more useful in discussions of psychotherapy to talk of horizontal cultures rather than vertical cultures. This means that perhaps middle class Americans in New York city are more like the middle class Chinese in Hong Kong than the lower socioeconomic class Americans in the same city. From this perspective, the idea of a culture-specific psychotherapy would make more sense, and this definitely agrees with my experience of having treated patients both in the Western society and in Hong Kong.

As the idea of role-induction (Hoehn-Saric *et al*, 1964) has shown, even in the Western society there is a need to clarify with our patients their expectations of psychotherapy. Logically, therefore, in a culture where psychotherapy has not taken root, public (and patient) education would be necessary. With increasing public awareness of the workings of psychotherapy, some of the problems we experience in the initial phase of introduction of this treatment method to our individual cultures would disappear. We should remember that therapist expectation might also work against ourselves if we believe that patients in our culture would not benefit from explorative psychotherapy. My experience in Hong Kong, of lower-middle class patients, is that this type of therapy is applicable.

In an earlier paper, my colleague and I suggested that with each psychotherapeutic encounter, the universal, the group-specific and the unique aspects of both the therapist and the patient are important considerations (Cheng & Lo, 1991), and that "every person in different ways is like all persons, like some persons, and like no other persons" (Kluckhohn & Murray, 1953). From this philosophical basis I feel, and I have found that with perseverance and persistence, that it is possible to use Western models of psychotherapy with a non-Western population.

CHENG, L. Y. & LO, H.-T. (1991) On the advantages of cross-culture psychotherapy: the minority therapist/mainstream patient dyad. *Psychiatry*, **54**, 386–396.

DOI, T. (1984) Psychotherapy: a cross-cultural perspective from Japan. In *Mental Health Services: The Cross-Cultural Context. Vol. 7, Cross-Cultural Research and Methodology Series* (eds P. B. Pedersen, N. Sartorius, & A. J. Marsella). Beverley Hills, California: Sage Publications.

HOEHN-SARIC, R., FRANK, J. D., IMBER, S. D., *et al* (1964) Systematic preparation of patients for psychotherapy – I. Effects of therapy behaviour and outcome. *Journal of Psychiatric Research*, **2**, 267–281.

KARASU, T. B. (1977) Psychotherapies: an overview. *American Journal of Psychiatry*, **134**, 851–863.

KLUCKHOHN, C. & MURRAY, H. A. (1953) Personality formation: the determinants. In *Personality in Nature, Society and Culture* (eds C. Kluckhohn, H. A. Murray & D. M. Schneider). New York: Knopf.

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SIR: I read with interest El Sherbini & Chaleby's letter discussing their difficulties in using Western models of psychotherapy in a Middle Eastern setting (*Journal*, March 1992, **160**, 425). This certainly accords with my own experience in using Western psychotherapy techniques both among Middle Eastern and Asian immigrants in the UK as well as Middle Eastern patients living in their country of birth.

In addition to the points mentioned in the author's letter, there are other culture-related issues in the therapy process. Most Western psychotherapies, whether psychodynamic or cognitive, encourage personal autonomy and individualism. In non-Western cultures, and especially Middle Eastern culture, social integration and acceptance is a much more valued attribute and, therefore, to go down the individualistic path carries a risk of real social sanctions and ostracism. One deeply embedded process in Arab culture is the early and consistent use of shame by parents, teachers and others as a method of ensuring social conformity and adherence to social values. The consequence of this is a deeply rooted and extremely powerful fear of social disgrace that is largely impervious to challenge or modification in the psychotherapeutic process.

One of the tenets of cognitive therapy is the Socratic method of questioning which assumes that no issue is sacrosanct and that the answer to many of life's conflicts can be discovered through the application of reason. This method soon flounders in non-Western patients when it is discovered that many of the emotionally significant areas are taboo to such a questioning process.

It is interesting that the authors have suggested an analogy between cultural development and individual cognitive development as described by Piaget.

This may be an attractive model to borrow but it seems to me that there are risks in doing this. Piaget's model of cognitive development assumes a *progression* through a number of stages where each stage is superior to the stage that precedes it. If such a concept is applied to the social context, the underlying assumption would be that certain societies are superior to others; a sort of 'march of progress' or social Darwinian view of human societies, so that, rather than accepting the differences in psychological make up of humans in different cultures as part of the phenomena of human cultural diversity that exists in our world, a value judgement will be implied of a culture's place in an assumed hierarchy. This would be a retrograde step of dubious scientific merit.

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Safety of 5-HT reuptake inhibitors

SIR: The letter from Waite (*Journal*, December 1991, **159,** 885) suggests that Healy (*Journal*, June 1991, **158,** 737–742) was over zealous in his recommendations of this new group of drugs. He quotes data from the Committee on Safety of Medicines (CSM) for fluoxetine up to July 1990 and it would appear he regards the numbers of adverse effects and deaths as excessive.

Up to September 1991 there were 16 recorded deaths on fluoxetine (CSM data): ten from cardiovascular events, one from liver disorder, and five from suicide (method not specified). Causality, however, cannot necessarily be implied and, interestingly, several of the cardiovascular deaths occurred in patients in their 90s.

It is almost impossible to compare CSM reports between drugs. Pinder's paper (1988) quoted by Dr Waite makes a number of interesting points in this regard. Firstly, reporting rates rose sharply in the 1970s (CSM, 1985) and most reports are made in the first few years of marketing a new drug. Secondly, higher antidepressant reaction reporting rates may not necessarily reflect a higher incidence of actual reactions. Thirdly, newer antidepressants may be selectively prescribed in patients in an 'at risk' population such as the elderly and those with cardiac disease. The older tricyclics have been available for so many years, and their side effects – such as cardiac toxicity, cognitive impairment and toxicity in overdose – are so well known that under-reporting is bound to occur.

Cassidy & Henry's (1987) work on fatal toxicity indices highlights the mortality associated with older tricyclics, and figures quoted from coroners' data on overdose deaths are far in excess of total deaths in the CSM figures. We should, therefore, be cautious in interpreting CSM figures in isolation.

The 5-HT reuptake inhibitors are relatively safe in overdose – for fluoxetine on an estimated patient base of five million worldwide, reports of death attributed to overdosage of fluoxetine alone have been extremely rare. Pharmaceutical companies who produce selective 5-HT reuptake inhibitors may welcome Dr Pinder's request in the last paragraph of his paper for an inclusion of overdosage risk in any considerations leading to recommendations for approval, renewal, restriction or withdrawal of product licences for antidepressants. The older drugs, however, may find that such regulatory changes will render them moribund.

PINDER, R. M. (1988) The risks and benefits of antidepressant drugs. *Human Psychopharmacology*, **3**, 73–86.
COMMITTEE ON SAFETY OF MEDICINES (1985) CSM Update. *British Medical Journal*, **291**, 1638.
CASSIDY, S. & HENRY, J. (1987) Fatal toxicity of antidepressant drugs in overdose. *British Medical Journal*, **295**, 1021–1025.

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Serotonin, eating disorders, and HIV infection

SIR: We read with interest Ramsay's article (*Journal*, March 1992, **160,** 404–407). We would like to comment on the exacerbation of symptoms of the eating disorder during the development of HIV disease.

Serotonin is one of the neurotransmitters which is involved in the control of food intake in physiological and/or pathological situations such as anorexia nervosa and bulimia nervosa (e.g. Blundell, 1984) in which plasma tryptophan and CSF 5-hydroxy indoleacetic acid concentrations are decreased (Coppen *et al*, 1976; Kaye *et al*, 1984).